

HEALTH ASSURANCE LLC			
NURSES NOTES			
Ortlund, John E.			
DATE	TIME		
Mdx: Cancer. prostate / Kidney			
2/ year			
Frt mdr. San Ramon			
Veterinarian			
Rx: no med.			
Current: cb bump on			
posterior part of head cb par			
to anterior chest area.			
- state was taken into a			
cell and beaten.			
(General soreness)			
PR			
INITIAL SIGNATURE		INITIAL SIGNATURE	
INITIAL SIGNATURE		INITIAL SIGNATURE	
NAME-LAST		FIRST	MIDDLE
			ALLERGIES
			INMATE #

NURSE NOTES

EXHIBIT A

HEALTH ASSURANCE LLC

CONSENT TO TREATMENT FORM

ORTLAND JOHN
NAME OF INMATE

9-8-04
DATE

7-2-40
INMATE #/DOB

I hereby give my consent to Health Assurance LLC, its employess and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician.

I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Health Assurance LLC.

I also authorize the transfer of my medical records or copies of said records to any facility to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this willingly in full understanding of the above and release Health Assurance LLC, its employees and agents from any and all liability which may arise from this action.

x John A. Guttman 9-8-04
INMATE SIGNATURE DATE

WITNESS

WITNESS

HEALTH ASSURANCE L

Harrison County Adult Detention Facility
10451 Larkin Smith Dr
Gulfport, MS 39503
(228)896-0646 Fax (228)896-0645

AUTHORIZATION FOR RELEASE OF INFORMATION

INMATE NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____

I, _____, hereby authorize _____
to release any and all of my medical record information to the above named facility.

Purpose of Disclosure: to continue treatment. This authorization includes the release of psychological, psychiatric, alcohol, drug abuse and HIV/AIDS data. This authorization included reviewing and/or copying all or portions of my medical record. I release Health Assurance LLC, Harrison County Adult Detention Facility and my physician from any responsibility or liability from the releasing of this information.

The patient has the right to revoke the authorization at any time by sending written notification to the above address. The revocation is not effective to the extent that this facility has taken action in reliance thereon or if the authorization was obtained as a condition of obtaining insurance and law provide the insurer with the right to contest a claim under the policy.

The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the privacy regulations.

I understand this authorization shall remain in full force and effect for the period of one year from today's date unless withdrawn in writing by me.

INMATE SIGNATURE

DATE

WITNESS

DATE